

**Arizona Department of Health Services
INVASIVE GROUP A STREPTOCOCCUS SURVEILLANCE
SUPPLEMENTAL FORM**

Complete Communicable Disease Report form and this form if:

- Group A strep (GAS) has been isolated from a normally sterile site; OR
- GAS isolated from a non-sterile site and patient has systemic disease (e.g., necrotizing fasciitis)

Case's name: _____ **Date of Birth:** __/__/

Date of admission: __/__/__ **Outcome:** ____ (1=Lived, 2=Died, 3=Transferred)

Disease(s) caused by group A strep infection: CHECK ALL THAT APPLY

- | | | |
|--|---|---|
| <input type="checkbox"/> Primary Sepsis (without focus) | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Gangrene |
| <input type="checkbox"/> Secondary Bacteremia | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Nonsurg. Wound infxn site: |
| <input type="checkbox"/> Pharyngitis | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Cellulitis/abscess site: |
| <input type="checkbox"/> Peritonitis | <input type="checkbox"/> Polyarthrits | <input type="checkbox"/> Other, please specify: |
| <input type="checkbox"/> Septic arthritis | <input type="checkbox"/> Endometritis/postpartum sepsis | |
| <input type="checkbox"/> Necrotizing fasciitis | <input type="checkbox"/> Surgical wound infection site: | |
| <input type="checkbox"/> Streptococcal Toxic Shock Syndrome (STSS) | | |

Clinical Signs of Severity

- | | | | |
|--|----------------------------|----------------------------|-----------------------------|
| Hypotension (Systolic Blood Pressure \leq 90) | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Renal impairment (Creatinine \geq 2 mg/dl) | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Coagulopathy (Platelets \leq 100,000 OR DIC) | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Liver abnormalities | | | |
| AST, ALT, bilirubin \geq twice upper limit of normal | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Adult Respiratory Distress Syndrome | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Necrotizing Fasciitis or Gangrene | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Erythematous Rash | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |

Complications:

- | | | | |
|--------------------------------|----------------------------|----------------------------|-----------------------------|
| Intensive care unit (ICU) care | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| If yes, given pressors? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| mechanical ventilation? | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Dialysis | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Debridement/myotomy/I and D | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |
| Amputation | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> DK |

DNR?

☐ Y ☐ N ☐ DK

Positive GAS cultures:

Source _____ Date __/__/__ Source _____ Date __/__/__

Source _____ Date __/__/__ Source _____ Date __/__/__

Date of symptom onset: __/__/__ (mo/day/yr)

Underlying illness or Prodrome: CHECK HERE IF NONE ☐

CHECK ALL THAT APPLY

☐ Chronic lung disease ☐ Splenectomy/asplenia

☐ Chronic heart disease ☐ Alcohol abuse

☐ Diabetes mellitus ☐ Injecting drug use

☐ Acute varicella (chicken pox) ☐ Tobacco Use

☐ Renal failure w/dialysis ☐ Asthma

☐ Cirrhosis ☐ Sickle cell disease

☐ Obesity ☐ Vasculitis/Lupus (SLE)

☐ Stroke ☐ Acupuncture

☐ Organ transplant type _____

☐ Malignancy (non-skin) type _____

☐ Pregnancy/Peripartum Due/delivery date: __/__/__

☐ Nonsurgical wound specify _____ Date: __/__/__

☐ Surgical wound specify _____ Date: __/__/__

☐ Blunt trauma specify _____ Date: __/__/__

Form completed by: _____ Date __/__/__

Facility: _____ Phone: _____

Mail completed form to: Infectious Disease Epidemiology Section
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